Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005043	A. BUILDING _____ B. WING _____	C 06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH HOSPITAL	700 BROADWAY FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of a State hospital complaint. Complaint #: IN00086331 Unsubstantiated, lack of sufficient evidence. Facility Number: 005043 Date: 06-23-11 Surveyor: John Lee, R.N. Public Health Nurse Surveyor St Joseph Hospital is in compliance with Indiana Hospital Licensure Rules 410 IAC 15-1.5-1, Infection Control, 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.5-6, Nursing services. QA: claughlin 07/15/11	S 000		